Physician Certification

Illinois Department of Insurance

Covered Person/Patient

first name _____ last name _____

Health Care Provider

treating provider name _____

address _____

contact person _____ email _____ phone _____

This form is to be completed as a supplement to the Request for External Review form, when the covered person/patient listed above has been denied a health care service or course of treatment on the basis that:

- the service does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness
- the service is for a preexisting condition which was present before the effective date of coverage,
- health coverage has been rescinded for reasons other than failure to timely pay required premiums or contributions toward the cost of coverage, or
- the drug, procedure or therapy has been determined to be experimental and/or investigational

The Health Care Provider identified above should complete Section A and/or Section B below.

Section A – Request for Expedited Review

Not available for care or services already received.

I hereby certify that in my opinion, the above named patient who has received an adverse determination for the medical services that I have recommended as medically necessary requires such review to be provided on an expedited basis because a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function or in the case of an experimental/investigational adverse determination, that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

Health Care Provider signature _____ National Provider ID (NPI) _____ Date _____

Section B – Request for Review of Experimental/Investigational Denial

I hereby certify that I am the treating health care provider for the patient named above in this external review and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the health carrier's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating health care provider I must certify that the covered person's medical condition meets certain requirements as shown in this form.

This section is continued on the next page.

Section B – Continued

At least one box within item 1 and one box within item 2 must be checked in order to qualify for external review for experimental/investigational denials.

1. The covered person/patient has a condition that qualifies under one or more of the following: Check all that apply. (must check one)

- ☐ standard health care services or treatments have not been effective in improving the covered person/patient's condition
- ☐ standard health care services or treatments are not medically appropriate for the covered person/patient
- ☐ there is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment

2. Check all that apply. (must check one)

- ☐ The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.
  explanation: _____
- ☐ It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person/patient than any available health care services or treatment.
  explanation: _____

Provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (attach additional sheets as necessary)
explanation: _____

Health Care Provider signature	National Provider ID (NPI)	date

Return this form to:

Illinois Department of Insurance
Office of consumer Health Insurance
External Review Request
320 W. Washington Street
Springfield, IL 62767
877-850-4740 toll free phone
217-557-8495 fax
Insurance.Illinois.gov/ExternalReview